certification, licensure, some of the issues that you raised in the taxonomy of the Minnesota Model.

MS. LARSON: You are speaking specifically of the taxonomy.

DR. GORDON: Yes.

MS. LARSON: Yes, we have a taxonomy. We also do have pretty clear definitions of what is universally understood as licensure, certification, registration. Those are clearly defined in this particular document. In terms of conversation, I think that we can enhance our work through more conversation so everybody can understand what we are talking about, but, indeed, in the document it is laid out.

DR. GORDON: Let me just go through what I have heard so far here. Essentially, in Recommendation No. 38, there is an appreciation of the value of the Pew Commission Report and a sense that some of the specifics of that report need to be spelled out.

When it comes to No. 39, there is a lot of question and discussion about the evolution of practice, and the committee said that they would go over the four stages, or the four aspects, of evolution that they

described and would refine that and, instead of giving single examples, give multiple examples and give a feeling for the different categories, a kind of broader feeling for the different categories.

I think there is still a kind of wrestling with this area that needs to be done, based on the discussion, in terms of recommendations about sort of the steps toward licensure. I think, incidentally, that this is partly where Don's comment comes in, is licensure the only route, and what about certification may need to be addressed -- I am sort of interpolating this -- may need to be addressed somewhere in the recommendations. Just a thought.

No. 40. The two sentences were put together and there was general agreement that No. 40 made sense and should go forward as restated.

No. 41. I think that we teased out the fact that there may well be two related but somewhat separate issues. One, specifically, is on the issue of scope of practice and some of the concerns that are arising as CAM is integrated, or not integrated, into different scopes of practice.

The other issue has to do, in general, with whether or not to make suggestions -- and, Joe and Linnea, correct me if I am wrong on this -- should there be some kind of suggestion, some kind of guideline for evaluating the regulatory mechanisms that are in place.

DR. FINS: I want to say, again, we are not saying there should be suggestions. What we are saying is the federal government should help catalyze a discussion, not to impose a direction, but to evaluate the risks and benefits of where you draw the lines, raising Don's question, all the way to a much more regulated stance. What is the best approach, with outcomes based on demonstration projects and assessment of the data.

DR. GORDON: Does that make sense to everybody, as stated by Joe just now? Okay.

No. 44. I think this actually applies from Nos. 44 through 48. There is more of a sense that the statements need to be stronger. They need to be broader in terms of looking at different aspects of integrative systems, what the actual implications are, particularly for underserved populations and populations at risk, and

that there are a number of examples of service that can be referred to.

In those examples -- and I think there was a general agreement to this -- that the examples give us an opportunity both to illustrate integrative and comprehensive services, and also to illustrate the principles, the sort of enlivening principles of the Commission, and that we can relate the examples to our principles, as well as to integrative care and to integrative service networks.

Joe Pizzorno, particularly, requested addressing some of the issues that had been in a previous document. So I think we need to be clear, have we indeed, in this document, addressed all those issues. Or, as Michele said, are they adequately addressed elsewhere. This may have to do, to some degree, with looking at some of the relationships.

A larger issue that was raised, I think, that goes back to this group, is what about the whole issues of wellness, health promotion, self-care, how much of that needs to come in. There was a pretty strong feeling that there needs to be, even though that is being treated

as a separate area, that needs to be very much integrated into some of the recommendations that are being made here.

Does that make sense, Joe? Are you with me on that?

DR. FINS: I think there is a micro-economic and a macro-economic distinction that needs to be made and issues of individual wellness, individual navigation, I think it is more an education or empowerment kind of area and not really in the infrastructure. The infrastructure shouldn't impede it, it should seek to encourage it.

I think that one of the things that I think we do have to do is to say, if someone is navigating the system that there is a continuum of care that is available to them, the panoply of services are available, and that providers from one domain can access the other. That, I think, is what this is about.

DR. GORDON: I think the other piece that I heard, not just from me but from several other people, is that the whole domain of self-care needs to be part of the integrative care system, that mostly when we refer to

integrative care systems, it is what professionals do to or for people.

I heard from several people, from Julia, and from Joe and others, and from Tieraona, that it also has to do with teaching people basics of self-care, of nutrition, that that is part of what people want access to.

Is that what everybody else was hearing as part of it? Yes? Okay.

Those really apply to Nos. 44, 46, 47, 48. No. 45, we are going to discuss and take up when it comes to the issues of cost benefits and payment mechanisms.

No. 49 is accepted as is, with the understanding that people who represent the indigenous healing traditions will be a part of this evaluation. Then there were two additional issues, which may or may not fit into access but are being brought up in the context of access, one of which is the one that I was discussing in terms of navigators or educators, which may be part of another area, but I brought it up in this context.

The other, Tieraona brought up, access to

products, as well as access to services. We have to decide, when we talk about it on Saturday morning, whether that is appropriate here, or whether that is appropriate somewhere else.

Anything, Linnea or Joe, that I missed -- or anyone else -- that wasn't addressed?

MS. LARSON: I don't believe so. I would actually just like to express my appreciation to all Commission members who have given some thought and some excellent advice, and I would really appreciate having their written suggestions.

DR. GORDON: Thank you. Thank you both. I want to thank you, particularly for all the effort, and for all the background information and some of the supporting documents.

Thank you, Michele, too, for helping to shape this.

[Applause.]

DR. GORDON: We are going to take a break until 11:30. Then we will come back and George DeVries will begin with looking at payment mechanisms.

[Recess.]

DR. GORDON: Before George begins, Tom brought up the whole issue of doing studies, and looking at the relationship between private practice and access and delivery. I just want to say that that is a new issue, and either we will be dealing with it here in this context, or we will come back to it Saturday morning. So, forgive me for omitting that in the discussion.

George, please go ahead.

MR. DEVRIES: Chair, before we get started, in terms of timing, it is 11:30. We will go until 1:00. In terms of amount of the time you would like to have?

DR. GORDON: What I would like to have, I would like if you could end at 12:45. Or, do you need to go to 1:00?

MR. DEVRIES: No, we can end at 12:45.

DR. GORDON: Perfect. That would be great, George.

Session VI: Coverage and Reimbursement for CAM

MR. DEVRIES: I want to thank everybody for the opportunity to discuss coverage and reimbursement, in particular, our workgroup members which included Joe Finns and Linnea Larson, Conchita, Dean and Ming, as

well as staff Maureen Miller, who supported our efforts.

As we get started, what I would like to do is instead of delving into detail right away, I would like to actually do just the opposite. I would like to go up to 20,000 feet, kind of talk, on a broad basis, what some of the observations were in terms of this workgroup, related to coverage and reimbursement, and really how we went forward with basically making the recommendations we have made, because I think it is important to understand it on, shall we say, sort of a broader level. Then we can begin to delve into the context of the details.

The primary issue, probably, related to coverage and reimbursement for this Commission, based on discussions we have had over the last year to year and a half, has really been mandating coverage versus working with the current health care delivery system, the current payer system, to encourage them to provide coverage. That has always been, I think, the discussion point that we have had.

Where we came to as a workgroup was down to one primary premise, with others following from it. The primary premise being those CAM services that are shown

to be clinically safe and effective should be covered. So, basically the recommendation of the Commission is saying that those services -- and we should say products -- those services and products that are shown to be clinically safe and effective should be covered.

Now, we recognize the challenges of our current health care delivery system and third-party payer system, that there are barriers out there. There are barriers for having services and products that are clinically safe and effective, to get coverage for them, as well as services that are provided but do not have the research to support clinical safety and efficacy.

So, as we began to go through our process of making recommendations to this Commission, it was really along those primary assumptions, and then saying, what are the barriers that we as a country, in fact that the CAM industry, faces, but really, all of health care in terms of obtaining coverage and reimbursement.

First, there is a variety of assumptions, but I would like to run through several assumptions that, basically, we have made. The current platform, in terms of providing coverage, whether that be health plans,

insured coverage, coverage through federal or state programs, that that is fundamentally the system we are operating in. That is the first assumption we made, how do we work within that system to obtain coverage and reimbursement for CAM services.

The second assumption that we basically made was we needed to look at the provision of coverage and reimbursement for CAM in the context of the many, many federal and state laws that exist to regulate the coverage and reimbursement of health care services. That includes both in state insurance and HMO laws. That includes even IRS statutes related to what an employer can cover as a benefit, a fringe benefit or employee benefit for their employees, even federal ERISA laws, that there are certain guidelines we are working within.

I think the third assumption is that, again, it is working within the context of our current platform, that maybe over a period of time, a decade or 20 or 30 years, perhaps how benefits are provided for Americans will change, but that is something in the future, that is different than what we have today, again, going forward on the basis of what we currently have.

Then really bringing us to a fourth assumption, given the current environment, what are the steps that we can take to increase coverage by health plans and employers. I think the challenges, some of the barriers we face, really, any change, for example, in benefits offered by HCFA literally require an act of Congress. Congress has passed a number of initiatives related to new benefits, but it has not provided funding.

So, there is, in a sense, a backup at HCFA, that really it would be literally where Congress not only approves the addition of a benefit for HCFA but approves the funding, and those both are critically important. That is a challenge, to obtain, especially in our current environment.

A second barrier is, health plans are hesitant to add coverage for services, especially those that have not been shown to be clinically safe and effective. There is a perception that they are trying to mitigate the continuing increase in cost of providing health care coverage, and so they hesitate to add anything to especially the basic coverage, the basic plans that would increase costs and might cause some employers not to

purchase coverage.

There is also a lack of information, both for governmental agencies, employers, health plans, regarding CAM services, clinical safety and effectiveness of CAM services and other areas of CAM.

Finally, I think there is a lack of collaboration between the health plan and insurance industry and the federal and state agencies that provide benefits and generally in the CAM industry. Therefore we really came up with a series of recommendations.

I would like to just summarize quickly, we will read the issues as we go through it and look at the recommendations, but specifically if we look at what the recommendations and we say, how would we categorize the recommendations we are making, the first thing is we are suggesting a dramatic increase in collaboration.

We are not just making another sort of support for more research, but it is really, yes, there is a need for research but there is the real need for collaboration, that the federal payers, state payers, that the health plans, the insurance companies, the employers be part of the collaborative effort to decide

the research that is done, to help to fund that research, so they are a stakeholder in this process, that as the results come forward, that there will be a higher likelihood that coverage will be provided.

I think the second recommendation is, we are obviously going to be supporting an increase in funding for research, both research related to clinical efficacy and safety, as well as research related to comparative health services research.

No. 3. It is basically going to be an encouragement to make sure that there is the appropriate legal authority in all states across the country for CAM providers to fully practice under their education and their scope of practice, i.e., licensure, certification, and registration. This will allow there to optimize the opportunities for coverage and reimbursement and the provision of benefits for CAM.

Fourth, is to elevate the billing systems and evidence-based criteria on medical necessity to improve the ability of CAM to participate in third-party reimbursement. And (5), to increase the availability of information to payers, so they can make decisions to

cover CAM.

So, before we really go into the review of the different issues and talk about the recommendations, I would like to invite my fellow committee members to make additional comments on our work.

Joe, Linnea, Maureen.

DR. FINS: I guess what I want to do is, just as an editorial comment, for the relationship between the two groups, there is really a regulation issue, and then there is access, delivery, and health services.

I think when we put the final thing together, these two sections may need to be deconstructed and reorganized, because I think that dealing with the issues of individuals, clearly, as you were saying earlier, whether or not someone is licensed has implications for reimbursement.

But independent of the reimbursement question, there is a regulatory piece, and we might want to have a regulation or regulatory section, and then access and delivery, and financing, and service delivery, just to put that on an organization. I think there is confusion about what is what, and what is access and delivery, and

what is regulation. They are related but they are different.

DR. GORDON: George and Joe, with your permission, can we see if people are feeling that way? Can we give some input to Joe and Linnea and George about this? Does that makes sense as a way to proceed? Effie is nodding yes.

DR. FINS: Just to have that in mind for after we go through the section.

DR. GORDON: Okay. It sounds like that is a reasonable way to think about proceeding.

MR. DEVRIES: Other comments?

DR. WARREN: About anything in this session?

MR. DEVRIES: No, I was asking the workgroup committee members for additional comments, just from a broad basis in terms of really looking at coverage and reimbursement.

MS. LARSON: My only comment is that I remember that we really did work quite a bit on the wording of specific recommendations, and that we really did want to, what George initially said, say clinically safe and effective, that that was a big threshold question.

MR. DEVRIES: Thank you, Linnea.

Any other comments?

[No response.]

MR. DeVRIES: Let's go ahead and start with Issue No. 1, Medical Effectiveness: Fair and impartial consideration of safe, efficacious CAM therapies.

Issue No. 1 really was primarily dealing with the issue of the recommendation this Commission makes to mandate CAM benefits for inclusion in third-party reimbursement, whether it be under government payers or private payers. Really, what the recommendation is saying is that if a CAM therapy is shown to be safe and effective, that it should be covered by the health plan, again, regardless of whether it actually reduces cost.

I think Dr. Ornish, Dean Ornish, pointed out in our workgroup that that is really the criteria that is held for other services, and his encouragement for our workgroup is that that should certainly be the criteria as we look to the coverage and reimbursement of CAM therapies.

Comments?

MR. CHAPPELL: George, then what do you do

about the concern for the increasing cost of health care in general, or for the plan? If safety and efficacy is established, are you assuming that that will be incremental, a benefit that is incremental?

MR. DEVRIES: The question of whether this then be automatic for a plan, this is really stated as encouraging, that could be covered, but ultimately, in our reimbursement system, Congress has the final decision related to HCFA and coverage and funding of benefits.

On the state level Medicaid programs, the states are going to have final authority. In terms of the states, there may be individually mandated benefits, or, if not, health plans will have determination over coverage. Employers that are self-funded, or ERISA employers, are certainly going to have the ability to make determinations.

So, we are really saying as a guiding principle, this is what we believe to be appropriate, recognizing that the challenge of rising costs of providing health care is a very, very real issue for all payers, and they are making difficult decisions.

Other comments? Joe first, and then Don.

DR. FINS: I think one of the operating assumptions that was implicit, I guess, in a lot of our discussions was that this was in the context of a global budget, whether it is an individual plan or the government, and that we wanted to have mechanisms to show that a new modality was cost-effective or value-added.

So, it is really looking at the allocation of resources that are already in place and demonstrating additional utility. That also sidesteps, to some extent, the issue of those people who have no access to any health care, because this is really in the context of people who are already under umbrella programs, as well.

MR. DEVRIES: Thank you. Don.

DR. WARREN: I don't know if this is the appropriate place, but in your introduction here in the first paragraph on Issue No. 1, the last sentence of that says: "The Commission supports an approach that does not prejudice one philosophy of health care over another, but treats CAM and conventional medicine the same."

Well, I don't see that being done completely. We give it lip service, but chiropractic has been proven to be an effective technique, manipulative osteopathy has

been proven to be an effective technique, but yet in modern medical practices, those are like the stepchild, they don't ever get recognized. They don't get used as much as they need to be used.

Are we recommending as a Commission, then, that they be viewed equally in the payer's mind?

MR. DEVRIES: The bottom line is if it is safe and efficacious, we are saying as a Commission that it should be covered, and that is where the workgroup finally came to that recognition.

However, it is also recognizing the barriers we face in our country, in our health care system. So as we look at the recommendations, it will talk about how to, we believe, facilitate the process of recognizing, for example, chiropractic, and basically reimbursing it, covering it as a benefit for the safe and effective services.

Would there be value moving to the next issue?

DR. GORDON: I just wanted to ask Don, in raising the question, what are you thinking?

DR. WARREN: Let me think about that some more. Sometimes I just raise questions. We will see what

happens.

MR. DEVRIES: David?

DR. BRESLER: So, we are making a recommendation that if it is safe and efficacious, it should be covered, and that is the extent of our recommendation?

MS. MILLER: If I might jump in here, I think as George has tried to point out, the initial coverage decisions are made by the purchaser, whether it is a federal agency, DOD, or CMS, a state or an employer. All we are recommending is that they be given equal consideration. The same way you consider conventional practice that is proven to be safe and efficacious, then that is the way you should also consider CAM services that have been proven to be safe and efficacious.

They may not cover everything in conventional medicine, and they may not cover everything in CAM. I'm sorry Dean is not here. This is a point, I think, he has argued in several groups, which is the fair treatment.

MR. DEVRIES: That makes sense.

Veronica.

MS. GUTIERREZ: I would like to respond with,

maybe, one answer to the Chairman's question. I see some real incongruency here when the Commission is saying here that the Commission supports an approach that does not prejudice one philosophy of health care over another, and yet when we talk about Title VII, we have got flagrant discrimination. I just want to put that on the table. These prejudices continue, and I will continually challenge them. Thank you.

MR. DEVRIES: Tieraona.

DR. LOW DOG: I think that one of the issues here is also, how are you going to determine, and who is going to determine, what is safe and effective. It is a big issue.

In one journal, something will say this worked, then there will be a systematic review. Everybody will say St. John's wort works for this. Then somebody will do one study, then all of a sudden it shows it doesn't work. It is a tricky issue, how you develop that when you are talking to people about making these kinds of decisions.

That is going to be one of the key questions, how are we going to know what is safe and effective.

Some of these things are not products, or an acupuncture, or a particular technique, but we are talking about systems and we are talking about entire professions and bringing them in. It is a complicated issue, and I just want to know kind of your thoughts on that, George, since this is what you deal with all the time.

MR. DEVRIES: You are absolutely right. It is complicated. It is difficult. I think if we begin to look through the draft recommendations, one of the key issues is collaboration, that, as you look at the design of the research and the methodologies, as you look at the funding of the research, that is really where Nos. 50 and 51 go to, which is saying, we are recommending that it is government working in conjunction with private foundations, private organizations, working with health plans, working with provider associations, to help develop the research methodology, to fund the research, to have, basically, multiple stakeholders in the process, so that when there are results that come out on the other end, that at least some payers will recognize them as credible and move forward with coverage.

It is also the recognize that, as this research

comes forward, what is the point of critical mass. There are people in this room, I think, who understand that issue far better than I do, in terms of how much research is enough to demonstrate that safety and efficacy have been demonstrated, but it is necessary from the standpoint of, I think, demonstrating to the health plans to encourage their coverage. It is also important for those, if there is a CAM central someday, here in Washington, and they are lobbying Congress for coverage under HCFA, to have these clinical efficacy and safety studies that they can point to and that, perhaps, where the government has participated at some level as a stakeholder in this, will help increase the visibility of those studies and thereby increase the opportunity to, perhaps, have Congress at some point make decisions that will approve not only providing a benefit, but providing funding for that benefit.

Effie?

DR. CHOW: It was related to safety and efficacy, and does that mean, in your first statement, that undergoing scientific investigation, and it automatically is approved for health plan coverage, what

happens to those that have not been researched under scientific rigor and that there has been by collection of results, outcomes, that it is effective? So I am, I guess, kind of reiterating the importance and the complexity of that.

MR. DEVRIES: I think there are levels, that whether it is a government payer, it is a private payer, it is a health plan or insurance company, there is a good, better, and best levels of credible research and reliable information that they can use to make decisions regarding coverage and reimbursement. The best is certainly having multiple research studies related to safety and efficacy that meet the scientific rigor that anyone in the organization would expect of it, that is certainly optimal.

There is probably less optimal levels of research that may be available or information on outcomes or information on patient satisfaction, which may not meet the highest levels of rigor, but, depending on the payer or the health plan, may be enough for them to make a decision in that area. Again, each organization may make a different decision.

DR. CHOW: So, in essence, like Indian healers and the other healers who are using traditional systems that haven't gone through anything, is that an impossibility right now to get funding, or energy medicine or spiritual healing, all of that, because we have been talking about the didactics that can be licensed, that can be proven, what about all those?

MR. DEVRIES: Generally, I would say that is a very steep mountain to climb at this point, even to the extent of where you could say some of these services quality as wellness benefits, and the IRS Code has very strict statutes on what can be covered under an employee benefits plan. Basically, unless it is recommended by a physician or really related to a medical condition, generally, coverage for wellness, as provided by a CAM practitioner, is not considered covered as an employee benefit.

DR. GORDON: I am wondering if we can move along. It is clear there needs to be more discussion about this whole issue of safety and efficacy. I am not sure that we can accomplish that here. We have 10 recommendations to go through. I am just wondering,

given the time constraints.

MR. DEVRIES: Thank you. I appreciate that. Can we go on and start with No. 50 and if there are some of the related questions --

DR. GORDON: Yes. Maybe the questions could come up in the context of the recommendations.

MR. DEVRIES: That would be great. Shall we start with No. 50, page 3?

It primarily is driving off of the collaboration process to have multiple stakeholders involved in developing the methodology and process by which the research will be done related to clinical efficacy and safety. We are not trying to replicate what the group on research has done, but take kind of a unique perspective on it.

Comments? Joe, then Tom.

DR. PIZZORNO: I think that is a good recommendation. In these parentheses where you list different public, private bodies, I think we need to include CAM institutions and CAM professions.

MR. DEVRIES: Thank you. Good recommendation. Tom.

MR. CHAPPELL: I am pleased, too, to have this recommendation. I am seeking some clarity around what you mean by a research plan. Are you saying sort of a partnership plan of why you exist and what it will encompass, and it will encompass CAM research, demonstrations?

I am not sure whether methodologies, data, priorities are as clear for me as I would like when you speak about a research plan.

MR. DEVRIES: Maybe we can make that clearer, but I think you are absolutely on the right track, which is, it is creating a plan about what are the areas, the modalities, the providers. It is the methodology that is going to be used, how the data is going to be collected, how it is going to be calculated, such that all the stakeholders, from the beginning, are saying, this is what we are going to do, this is how we are going to do it, and therefore they have buy-in to the whole process so that when the results come, there is buy-in from the front end.

MR. CHAPPELL: Thank you. So, on the question of the threshold of safety and efficacy, you are making

the statement of clinical safety and efficacy?

MR. DEVRIES: Yes.

MR. CHAPPELL: That was the word you used in your introduction. In the public/private body plan, would we be looking for a different word than "clinical," like "outcome-based" evidence?

DR. FINS: Joe, along those lines, I think, to answer Tom's question, we might look at bed utilization, we might look at pharmaceutical costs, we might look at prevention, wellness, absenteeism. It kind of goes with No. 51, as well. If you were to have a system in place, what is the impact of this integrated system on the well-being and the disease status of the population under study.

It is kind of like the Framingham study for cholesterol and tracking a community, where you could follow out and see whether their disease indicators deviated from national norms because of this kind of investment.

MR. DEVRIES: In terms of using phrases like "outcome," I believe certainly those are important measures, but I think it gives us some consistency in

terms of tie-back to other areas of our report focusing on clinical efficacy and safety; however, it doesn't preclude the process to say there are other important elements that we want to study at the same time, which include outcomes. It also could include other benchmarks.

MR. CHAPPELL: But by clinical, we still have plenty of latitude of how we would design that clinical study?

MR. DEVRIES: Absolutely.

MR. CHAPPELL: Yes. Okay.

MS. MILLER: I might just add that on the phrasing about methodologies and data, I think this was an effort to, when this body is convened, that issues unique to health services research and data and what bill and claims data is available for conducting these studies, that those issues can be addressed so all parties are dealing with them at the same time, rather than each research group struggling with that individually, that we put a lot of minds from a lot of different parties together to resolve those particular issues, some of which have come up before this

Commission.

MR. CHAPPELL: I think it might be helpful if we identify some of the public and private bodies that have come before the hearing process, just so that the recommendation actually identifies potential partners here, because otherwise the recommendation might be a point of departure, but the people would have to start over. Whereas, there are players that have come here that have said they would like to be involved in such a partnership.

So, by being impartial, we could list some of the people that have presented here around this.

MR. DEVRIES: We would probably need to get their buy-off on that, but you are absolutely right, there have been plenty of organizations that have come forward and said they would like to participate.

Ming.

DR. TIAN: I think the recommendation, it would be very important to mention, you mention on your first page, that some CAM practice should be first considered. I think we should consider those that are licensed first. I have a little bit of problem, if it is not licensed,

how can we work on the coverage. It is difficult if the CAM therapy is not licensed.

If it is licensed, it means it already shows that there is some evidence which it is safe and effective.

So, page 1 will mention that, where there is such evidence, the evidence has to be more specific, for instance, at what level. For instance, it is proved by an NIH conference like acupuncture, or it is licensed in 50 states as a chiropractor. We have already got the evidence. You can't say one scientific paper would be the evidence. Then you need some people to review, to have experts review.

But, again, I think more specifically, we should mention that. It is my opinion, at least in all the CAM therapies and the products, some of them already are qualified to be covered, to be reimbursed. Then we continue to do more, get more evidence, and to show more and more we have got the evidence. You mention that it is safe, effective, we continue to do that.

I think we need to mention that, because even Medicare does not cover acupuncture, for instance. In

1997 it was approved by NIH. They are still not doing that. We need to mention that, because that is important.

Again, we are back to the present order. We are trying to help people to maximize the benefits. I don't think that is right, if we already have evidence, you still don't do anything.

MR. DEVRIES: That is why, as we talk through this, it is a process to help break down those barriers and to increase coverage. Hopefully, as we walk through all the recommendations, you will see the recommendations all work together to help cross those barriers as that evidence is already there.

DR. GORDON: I wanted to do two things. One is to encourage us to move along. The other is not to load too much on this first recommendation. There are nine or 10 others, and I think this one is very general, and is deliberately, I think, kept general.

Ming, I think you will see, later on, when the recommendations get more specific. So, I think we need to keep moving, and some of the other issues that everybody has will come up.

MR. DEVRIES: I think Nos. 50 and 51 are generally tied together. One is about collaboration and creation of the research. No. 52 is about joint funding and not relying strictly on the government, but trying to encourage collaborative efforts related to funding.

Any other issues there? Move on to No. 52?

DR. GORDON: You were asking about both Nos. 51 and 52, right?

MR. DEVRIES: Actually, Nos. 50 and 51, because they were related, basically. I was feeling that we could move on.

DR. GORDON: I think people need to take a look at 51, because I haven't heard the questions address that yet, so I would like to get a sense if there are any issues first with 51 before you go on to 52.

MR. DEVRIES: Okay. No. 51?

[No response.]

DR. GORDON: Okay. That is fine.

MR. DEVRIES: No. 52. I think this addresses part of Ming's question, what is the process, if there are studies available that certain CAM modalities or products have been shown to be safe and effective, what

is the process. It is really encouraging purchasers to develop and maintain a process to evaluate coverage for effective and safe CAM services.

We need to recognize health plans do have a process for evaluating coverage.

DR. FINS: One of the areas that might be very helpful for the background section, for two reasons, is the Oregon Plan experience in the early '90s where they got a waiver from Health and Human Services to initiate the Oregon Plan and have a diagnostic treatment pairing for Medicaid beneficiaries. They had a method of linking cost benefit analysis and public input into creating a categorization of like 600 or so diagnostic treatment pairs.

So, there is a process that might have utility to draw upon here in just discussing how we might consider what is value-added, what is effective.

The second point is when they did their first go-round, they had actually left out mental health coverage in the first go-round, and it was just physical medical issues. People said there should be parity for mental health and that it should be included. On the

second go-round, they included mental health.

So, I think there is a parallel argument here. We are saying that if a CAM modality is safe and effective, it should be included in the current structure of what is covered, just as the mental health piece was integrated into the Oregon piece. So, I think there may be some background there that might be helpful to make the argument.

The point of this is not that we have to demonstrate scientific or efficacy kinds of considerations. The fact is we are saying that if that is there, you are making a philosophical statement that there should be coverage if it is safe and effective, as good as, or better than standard of care, it should be included.

MR. DEVRIES: We could perhaps get some background on the Oregon Plan, look at that in the workgroup. Okay. Thanks, Joe.

Anything else on No. 52?

DR. GORDON: I just have one question there with the word "encourages," which you sometimes use. It is not as strong a word as "recommend." Why have you

chosen the wording? I guess I am saying I would be a bit stronger with this. I would recommend, because encouraging is nice, but --

MR. DEVRIES: "Encourage" versus "recommend," I think those words both are workable. Okay. Thank you.

DR. GORDON: Does that resonate with other people, as well? Okay, good.

MR. DEVRIES: No. 53 is really -- and we can say the Commission recommends, based on the Chairman's recommendation -- but, basically, I think No. 53 is really about encouraging CAM providers and provider associations to, where appropriate and where there are opportunities, to participate in this process of helping to establish coverage and develop benefit programs.

MS. MILLER: I might just back George up by saying that I think this gets to some of what Ming was bringing up, and others, that there is there process out here, and what we are talking about is that the people who run the processes should now include CAM, that is what we are recommending, and, likewise, on the other side, the CAM professions should become involved.

So, it is a balanced approach. It is really

helping the current process work.

MR. DEVRIES: Comments? Yes.

DR. GORDON: I think it is very good. I am just wondering if there can be some more background justification for doing this, because the people who came to talk with us from federal agencies and elsewhere got interested, but in the course of talking with us, if you follow what I am saying. There has got to be some process that engages them.

I know you have some of the background information here, but I think the stronger we can be in making the case for why they ought to essentially change the way they are doing business, reach out and say to CAM professionals or CAM researchers, we want you on our advisory committee, we have got to give them a series of good reasons to do that.

I would like you to formulate what those reasons are, and then present them, not necessarily in the recommendations. Some of them may actually be part of the recommendations, some of them may just be the background.

MR. DEVRIES: Okay. Any other comments on No.

53? All right. We will move on to Issue No. 2, Cost Effectiveness.

Obviously, we have talked about clinical safety and efficacy as a key determinant in offering coverage for CAM, but if you look at it from the health plan's perspective, the payer's perspective, if you look at, how is Congress going to make a decision for coverage of CAM under Medicare, it is really going to be about, in many cases, here is our budgeted amount for health care benefits, here is what we have got available; what is this going to cost, and what is going to be the impact on the overall cost of our benefits plan. It becomes part of the decision-making process for payers.

There is more pressure, shall we say, on that process now than ever because of the rising cost of health care in general, related to pharmaceutical products and technology, as well as with an impending recession, there is more pressure by employers to try to keep those benefit costs down.

So we identified, as a workgroup, this as a key barrier. This is a key barrier in the whole process of adding CAM benefits, getting CAM covered and reimbursed.

This Issue No. 2 really is about making a recommendation related to comparative health services research to demonstrate that if you take two pools of members and one pool of members has a basic medical plan without CAM coverage, the other pool of members has, in a sense, the same medical package, medical benefit plan, plus it has one or more CAM benefits, then looks at those two pools of members over time and compares the overall cost of health care for those two pools, that there can be a demonstration through that research that the pool of members that have CAM benefits, what is the impact of CAM, does it raise costs.

If it does, is it a little, is it a lot, is there simply cost offset and there is no difference in cost, or is there perhaps cost reduction, where CAM helps to reduce the overall cost of health care.

This is a critical area of research. We decided to separate it out, as a workgroup, because it is such a significant barrier, and because, frankly, there is good, solid, clinical efficacy and safety studies related to chiropractic and other areas of complementary health care. But, frankly, there is not good comparative

health services research out there to truly help.

It is the sense of the workgroup that with this kind of research, and with positive results from this research, it will truly drive coverage and reimbursement for CAM.

Maybe we will just start with Issue No. 54. If you have questions, in general, regarding this specific section, but we can start. Effie, and then David.

DR. CHOW: That sounds really good. Point of clarification. The ones that offer CAM, can they choose only CAM, or do they have to choose the medical package and then add CAM to the treatment?

MR. DEVRIES: That is a good question. I will share with you, in my business life I work with health plans to provide complementary health care. My experience has been that regulators require us to only provide coverage for CAM services for members who have a medical plan in place.

DR. CHOW: The question is, do they have to have medical treatment, or can they choose just CAM treatment?

MR. DEVRIES: In terms of choosing treatment,

it is freedom of choice.

DR. WARREN: Don't they talk about medical necessity? You can't get a CAM referral unless you have proof of medical necessity, as a way of not paying. That limits the selection of the patient, the choice of the patient, in whether they would rather have a CAM therapy or a conventional therapy.

MR. DEVRIES: Well, there are really two issues there. One is in terms of establishing medical necessity. Most health plans will require medical referral, which, Don, I think you are right, it becomes an access issue. There also are plans, even under traditional HMO systems, that will allow direct access to CAM providers, such as chiropractors or acupuncturists.

So, it is important in any type of research like this that those kinds of key factors are indicated.

David.

DR. BRESLER: My question cuts across a bunch of your issues, but I think it needs to be raised. It has to do with preventive medicine and wellness. Many years ago, I was doing some research on hypertension, and was shocked to see that compliance of patients given

anti-hypertensive medication is about 50 percent. When these patients don't take their hypertensive medication, they develop heart attack, strokes, kidney failure, all of which are catastrophic in terms of their cost.

I think the evidence of cost-effectiveness of taking medication or doing these interventions is overwhelming. And yet, when we tried to approach the plans and say, here is an intervention, here is a CAM-type intervention to increase compliance, they didn't get it at all. There was no understanding at all.

I think the evidence for wellness as an intervention to prevent catastrophic costs is very, very strong in a lot of areas. And yet, again, the medical necessity issue is one.

Why are the plans not embracing CAM and a lot of these modalities in wellness programs and providing these kinds of benefits in order to reduce their costs?

MR. DEVRIES: I think that gets into a level of speculation. I am not sure that there is a lot of value in getting into that. I think we all understand that there are significant barriers there, and we are trying to create some concrete methods that will help us get, at

least, over some of those barriers.

DR. GORDON: David, one thing I would suggest, and I actually heard this in the last three questions, is, if there are recommendations that you have for other kinds of cost benefit studies, that is what George needs to hear.

In each of the questions, I am hearing some aspect of a recommendation. I think that is what this committee needs right now, for you to tell him what you think. Now, we can't go into all the details. I think our task here is, if there are other issues, like the ones you have been raising, that need to be considered by this committee, you need to tell him what those issues are, and then follow up with him and the other committee members to help define those issues.

DR. BRESLER: I am addressing Recommendation No. 55, specifically.

MR. DEVRIES: Can we deal with --

DR. BRESLER: Well, it cuts across a bunch of them, but the question is, just because cost-effectiveness has been demonstrated doesn't mean anything, it seems to me, in terms of a change in the

policies of these plans, in terms of what they are going to cover. I would like to see us take a stronger stance on it.

DR. GORDON: So, the challenge back to you is, okay, what now. I am not saying you have to answer that question now, but that is what you and George need to have the dialogue about.

MR. DEVRIES: Joe.

DR. FINS: This points to why we really need health services research and population studies that transcend individual plans. I think they are getting at that in some of these recommendations. The problem is with any preventative strategy is if you do the mammogram and you do the polypectomy and prevent the colon cancer, that cost, say for the colon cancer, was 10 years from now in a different plan. The patient is going to have jumped from three plans from now.

So, we really need to have long-term longitudinal studies, like the Framingham tracking of a population, to really understand whether this is cost beneficial or not and whether it promotes wellness.

So, it really has to be a population-based

study. I think that this is totally constant with the kinds of goals from Health People 2010 and it really needs to be enveloped in the United States Public Health Service, the kind of work that they have done so well.

Now just bringing in additional variables and having population-based tracking, because of the complexity that David is alluding to, you can't do that with a single plan. We can say a modality works or not and whether people are happy or not, but whether it affects costs and mortality and morbidity and absenteeism and all those big issues, we need a population kind of study. So, we should make a recommendation.

MR. DEVRIES: I think we can maybe add some wording to what we have got, in terms of some of our recommendations, to help there. Understanding that employers, health plans, government payers have certain options and choices in how they build their benefit plans. So we are trying to create ways to overcome those barriers.

Let's look at draft recommendation No. 54. Are there particular comments related to that draft recommendation? We are going to add some wording based

on Joe Fins' comments.

SISTER KERR: I really don't feel a particular expertise in this, but if I can say it, some of what Joe said, the whole idea that a person will have three different funding sources, perhaps by changing jobs, that the incentive is not for the first business to do wellness work, because they are not going to be around anyway, if you have gotten the colon cancer 10 years later, right? So they don't have an incentive putting all the money in for wellness, correct?

Now, the federal agencies would, because they are going to take care of people and have their health insurance for life and retirement.

I am making some intuitive leaps. Going back to our principles, going back to our world view, if we have a national goal to keep people well for a lot more reasons than to have a healthy country, and principles like we care about one another and we are building community, this is sort of going out of your whole, incredible work to say, how do you make a recommendation, how do you incentivize everybody so that we, in fact, want to keep people well, whether or not they are under

this insurance policy now or later, in the same way we have funding to take care of child health. If you don't do it then, you can't do it in 20 years.

I know this is probably opening up conversation about national health insurance, but I don't want to go there. That is almost like still buying into the system, I think, is bankrupt and hierarchical and authoritative, and not in our power, Don.

How big can we get in thinking about this? It is definitely out of the box, but I think it is a national goal.

DR. GORDON: I appreciate your remarks, Charlotte, because it highlights something for me. I would say that these statements could be made much more strongly. This relates to what David was saying earlier, as well as what Charlotte is saying, that it is time to do some significant studies on whether self-care, just as an example of one that is stated, the cost and benefits of self-care and working with people who are particularly vulnerable to chronic illness.

Some statements that are stronger than we have made them here, I think we are in a position where we

should be doing that. We should be doing it now on a large scale. It may wind up taking a number of years, but once we get it started, I think we will start seeing the benefits. That is what I would like to suggest.

MS. MILLER: We will add that as a new recommendation.

DR. LOW DOG: It goes here, I guess, too, but also under the self-care, where really following through to see how it impacts health.

I think Charlotte is right, it is a bizarre situation because of all the changing. My patients, their insurance changes. Every four and six months, they have got something different. So it is hard.

I think that is where the federal government may be able to step in, also, working with Public Health Service, and working with some of these other groups to fund some of these studies to show the impact that this has.

MR. DEVRIES: If you look in the context of wellness in terms of self-care related to good nutrition and exercise, and just certain fundamentals, I don't believe it has an impact 10 and 15 years from now. I

believe it has an impact in 90 days to 12 months. People see positive improvements in their health care that quickly.

On the one hand, I understand some of the impact is 10 years plus, but I have got to believe the majority of the impact, especially in those kind of areas of self-care, is very short-term. Therefore, I think it supports what we are saying, which is, there is value to the health plans funding it.

I think part of it is we are saying, given the system we currently have, how do we demonstrate that through research and other activities, how do we demonstrate that, and how do we basically move the current health care system to not just including coverage for clinical services like chiropractic and acupuncture, but areas of self-care like nutrition and exercise and others.

SISTER KERR: In terms of short-term impact and, actually, what do people ask for, Bernadine Healey, as everybody knows as head of Red Cross, was speaking with some members of Congress. At the Pentagon site -- this is just to go into immediate care, and this is the

short version -- as we all know, everybody needed their first aid, whether it was washing out the eyes, and they had everything else there, of course.

But, do you know what one of the top requests was? They wanted to talk to somebody, and they wanted spiritual care. I am telling you, that is what is getting those people through. It isn't validated in this study, and it is not covered by an HMO. It is what people need, and are going to need for quite a long while, with immediate results.

MR. DEVRIES: Joe.

DR. FINS: I was going to say bereavement services is another issue that comes up.

I think, in a sense, the wellness, I think, is less necessary to prove, because if we were doing Framingham today, we would call it a CAM study. It is about smoking cessation, it is about exercise, it is about good diet.

I think what we really need to prove is to prove that interventions and delivery systems, not necessarily wellness, I think we all know wellness makes a difference, but how do integrated service delivery

systems impact on morbidity and mortality?

DR. GORDON: We have 12 minutes left. We have about seven more recommendations. Even if we give you another eight minutes, so I am left with seven minutes at the end, still we have got to move.

What we are looking for is not the answers to this. We are looking for direction. I think we are getting the direction, but let's focus. We have about seven or eight more recommendations, and George and his group need guidance from us about other issues that should be addressed.

MR. DEVRIES: On some of these more complex issues that we have just been talking about, we would welcome you, if you want to put something in writing or join one of our conference calls with our workgroup, please do.

Back to Recommendation No. 54. Anything else there?

DR. GORDON: No. Move on No. 57.

DR. CHOW: I just wanted to say that that recommendation, the last sentence there covers what we are saying. I would make that stronger and expand that a

bit.

MR. DEVRIES: Are recommended?

DR. CHOW: Yes, because that takes in what we were discussing.

MR. DEVRIES: Thank you. Joe?

DR. PIZZORNO: This actually may be more appropriate to the staff writing this, this particular recommendation, but I am noticing that we are often just saying CAM modalities or CAM therapies. We need to continue to include CAM systems and CAM practitioners. I know there is about 100 places where I have noted this in these notes. So I would just like to request that we are looking at not just modalities, we are looking at systems and practitioners. We just have to be more careful with that language.

MR. DEVRIES: So, No. 54. How about No. 55? We have really talked about that. No. 56.

DR. FINS: Just on 55, I think it is very vague. We are not recommending they cover something. It is really they cover in the context of what their allocation scheme is, depending on how much money they have. It may be safe and effective, but they may not be

able to afford it, and they may have other priorities.

So, I don't know what we are really trying to say here. We want to say they should not be prejudicial against a modality that is safe and effective, right? But we are not recommending that they actually cover it, it is just that they consider its coverage in a non-prejudicial way.

MR. DEVRIES: Right. That would be a good topic for the workgroup. Would that be all right? I think that is an issue we could spend a fair amount of time on, but I understand.

DR. JONAS: I actually like the wording in this thing, because it does say consider. It is not saying fund. It is saying, we recommend that if something is proven safe and effective, then the various agencies, taking into consideration all the other issues that they have to take into consideration, consider funding them.

I actually like a lot of that kind of wording, which is spread through many of these applications, which is less confrontational and more integrative in approach. So, I commend you on that.

MR. DEVRIES: Thank you. Are we ready to go to

No. 56? No. 56 really is about encouraging federal programs to have an ongoing effort to evaluate the benefits, so that there is a process that ultimately gets us there. Comments there?

No. 57.

DR. FINS: This might be, if we come to a CAM central sort of approach, there needs to be some mechanism to close the loop on what all that data shows, those administrators, where they report and who culls the data and makes sense of it.

MR. DEVRIES: Right. Later there is a recommendation in terms of collecting information to give reports to Congress. Certainly CAM central would be critical if there was that type of report.

All right. No. 57, this really relates to making sure that the CAM professions are evolving their CPT coding to reflect the services, so that they can be appropriately reimbursed in third-party reimbursement systems. Yes, Joe.

DR. PIZZORNO: We had quite a bit of discussion about this, and I think we have to walk carefully. I am concerned that if we develop CPT codes that are just for

CAM therapies, interventions, and practitioners, we run the risk of ghetto-izing those groups and having progressively decreased reimbursement for them. When we do a primary care intervention, whether a chiropractor, naturopathic doctor, medical doctor, et cetera, we should all be involved in the same CPT code and not have separate CPT codes. So, I want to be careful with the language that we don't segregate ourselves out.

MR. DEVRIES: Thank you, Joe.

Anything else there? Ready to move on to Issue No. 3? Issue No. 3, which is acknowledging that licensure is a minimum issue for most health plans or payers and therefore we had one recommendation, which is No. 58 on page 7, that, basically, to increase access and coverage of CAM therapies is to really encourage state agencies, to make sure that they are appropriately licensing, certifying, registering providers consistent with their education and scope of practice. This, ultimately, is going to result in more coverage, more reimbursement, better access to these services.

DR. GORDON: I think it is a good recommendation. I think it is one of those that needs to

be tied back into the other sections on licensing and credentialing.

MR. DEVRIES: Right.

DR. JONAS: I find it a bit confusing, because you mention that if there are safe and effective therapies that then it encourages governments to grant authority to practice professions. Perhaps that needs to be reworded a little bit, because the goal here seems to be when there are safe and effective therapies that there be a method of allowing them to be covered and have access to them. It just seems to be mixing a couple different things, maybe just rewording that.

MR. DEVRIES: I think you are right on that. I think the workgroup needs to do some work there.

MR. CHAPPELL: Again, I am thinking of what might be an operating idea to advance this. I am thinking about a national meeting of the Association of State Government Health Care Departments to dialogue about various CAM modalities, state to state.

I think when you get people out of their own state and mingling with other people across the land and they see what other states have done to bring this into

coverage, it gives them a little more incentive to do the same in their own state.

MR. DEVRIES: Perhaps the federal government can support or facilitate that process of governments sharing information.

DR. FINS: This is what we were talking about in our last group, the Uniform Code. Our last recommendation was to catalyze this very dialogue. So I think it is there.

DR. JONAS: There is a forum already for doing that, too, which is the National State Legislators, which has an annual association and have had forums at those meetings on CAM licensure, practice, and this type of thing. So, to facilitate that process and stimulate it would be one way to do that.

DR. GORDON: I am trying to get clear, we are looking for a way to put this into practice. Is that right? And we haven't exactly found the way, but there are a number of suggestions.

MR. DEVRIES: Part of the fact, and I believe it goes back to there are ways to do it, and one of the ways to do it is simply making the recommendation in the

Final Report, because if the recommendation is put there, I believe it provides clarity as a recommendation to state legislatures. There are grass roots efforts out there by providers trying to improve the licensure statutes of their state or to create a licensure statute in their state, and the Final Report in references related to this simply provides them with very real, concrete support that they can point the state legislature to.

So the facilitating process by the federal government is excellent, but don't minimize the value of just having it in the Final Report that it can be something they can reference.

DR. GORDON: I would say that we are now splitting it. There are two recommendations here that you need to go back and think about. One specifically has to do with saying to the states, you should consider licensing these people. The other has to do with an action step of bringing responsible people in the states together to look at the issues. Is that correct?

DR. FINS: I would just refer us all back to our recommendations 38, 38, 40, and 41, and the

background sections and the taxonomy, because all of these things are related to this charge about establishing legal authority, ultimately to improve access in a safe and secure way.

MR. CHAPPELL: But, yes, you are right, Jim.

DR. GORDON: Okay.

MS. MILLER: We will work with access on that.

MR. DEVRIES: Thank you. Anything else on Issue No. 3, licensure? This recommendation, we will take it back, we will work on it, we will split it into two recommendations.

Moving no to Issue No. 4, which was really the issue of the concept of medical necessity, that basically health plans use it as a definition in terms of what to cover, employers use it as a definition of how they would define their benefit plans. The IRS Tax Code uses it as a stipulation of what can be covered as a fringe benefit, what employers, therefore, can deduct as an employee benefit plan, and what employees can receive, their employees and their dependents can receive as a tax-free event, as a tax-free benefit. So, it is language and medical necessity requirements are broad based.

DR. BRESLER: It seems to me that this IRS statute completely dis-incentivizes insurance plans from providing any wellness benefits. Again, here seems like an area where we could make a very strong recommendation, not to tell the IRS what to do, but I don't think government should be dis-incentivizing prevention and wellness programs by making them taxable events.

MR. DEVRIES: Just to understand the magnitude of it, there is a senate bill that has just been introduced, the Dietary Supplement and Fairness Act, which is all about the Tax Code issues, and it is sponsored by Senator Harkin and Senator Hatch, and basically it is about allowing employers to buy coverage for vitamins and herbal supplements and that it be considered a fringe benefit.

I am saying that this is an issue out there.

DR. BRESLER: Can our Commission make stronger recommendations about not dis-incentivizing wellness and preventive programs in this way? Isn't this something we could do?

MR. DEVRIES: Yes. We are going to take that back, in terms of making recommendations along those

lines, because we have not done that here, and it is something that even just in this meeting we have been talking off-line about the IRS Code statutes and their impact, really, on coverage and reimbursement.

Effie and then Joe.

DR. CHOW: On the issue about incentive for wellness, there is a program -- and this has often been my ideal, and it is going way out there -- but there is a very large organization in Wichita, Kansas, The Improvement of Human Function, Dr. Hugh Reardon, a physician who does workmen's compensation assessment and everything, they offer wellness day instead of sick days. Is that too far out to pose that type of a query or recommendation? They get wellness days, they do not get sick days.

MR. DEVRIES: I think that might be more under the self-care and the wellness that we will be discussing later. Thank you.

Joe, and then I think we are going to move on, try to, if we can, look at the draft recommendations quickly.

DR. PIZZORNO: Just a quick question. Does the

proposed legislation include in the IRS deduction prescribed supplements as being included for the deduction?

MR. DEVRIES: It is broad based in terms of nutritional supplements.

DR. PIZZORNO: You said one is for coverage if it is part of a health care plan, but if it is just prescribed by somebody who is not on a health care plan and they had to buy it themselves, is that included?

MR. DEVRIES: No, that is not covered.

DR. GORDON: I'm sorry, I have a question. Aren't we discussing Recommendation Nos. 59 and 60? Or, are we?

MR. DEVRIES: We are.

DR. GORDON: I don't know that we have addressed the recommendations yet. I may have missed something in the discussion.

MR. DEVRIES: We have gone a couple different directions.

DR. GORDON: Okay. So, we have eight minutes left. We need to address these and decide what to do with them. I am not saying we shouldn't talk about the

other issues, that goes back to the committee; but what about these two recommendations, they need our guidance about that.

SISTER KERR: I just wanted to clarify, the senate bill was to give a break so that people could pay for the drugs to be a fringe benefit for the employees, correct?

MR. DEVRIES: It was to allow employers to buy coverage for nutritional supplements. I will get you a copy of the bill.

SISTER KERR: I will tell you why I am asking. Was it nutritional supplements?

MR. DEVRIES: Yes.

SISTER KERR: All right. I will just let it go.

MR. DEVRIES: Shall we go to Recommendation No. 59? Comments?

[No response.]

MR. DEVRIES: We will change "encourages" in both Nos. 59 and 60 to "recommends." Anything else? How about No. 60?

DR. GORDON: I think that maybe the previous

discussion comes in here, where we talk about bringing wellness in, giving a sense that medical necessity, which always seems to have the feeling of overwhelming response to a life-threatening illness, that we introduce here the concept that is different, a focus on health and wellness is some aspect of medical necessity.

Maybe that is why there has been so much discussion of those issues in relationship to this group of recommendations, that that is what we are trying to reach for. I am not sure about that. That is as much a question as it is a statement, but I feel like that is what is missing here, that we need to expand the definition of "medical necessity."

MR. DEVRIES: The challenge is the definition of "medical necessity." We can make a recommendation related to a "medical necessity" definition, but the "medical necessity" definition that is used by payers is one that, I think, is probably more strict. I am just saying we can make that recommendation, but recognizing that this is a fairly well-ingrained part of the structuring of employee benefits.

David, and then Joe.

DR. BRESLER: I would suggest that your committee take another look at worker's compensation code, because, as a primary treating physician under Comp, when I say it is medically necessary for wellness interventions in order to maintain a permanent and stationary status of a patient, wellness interventions are accepted under Comp.

DR. FINS: Another way to get inclusion, without getting into the thicket of medical necessity, is to encourage plans to have the membership articulate their preferences for what gets covered, what doesn't get covered, a la Puget Sound, which is very well known for its membership inclusion in establishing the benefits.

If there is money left over, and it is discretionary, how does it get distributed. There should be a kind of community involvement of shareholders, members of plans, that kind of language.

DR. GORDON: My response, that is a great idea, and that is really a whole new recommendation that we haven't included yet. I think it could be very important and probably in this section.

MR. DEVRIES: What I have seen is where

employers can choose to purchase benefits that are more restrictive, less restrictive in terms of an application of medical necessity, and they are priced accordingly. The one perhaps costs more, but is valued and therefore paid for.

DR. FINS: It is the marginal cost that is really what is up for grabs, and that might be exorbitant, but people should have the ability, perhaps, to make that marginal choice for a carve out or supplemental or something.

MR. DEVRIES: And I think you are seeing some health plans who are moving in that direction within their plans to have more options there.

Tom, did you have a question?

MR. CHAPPELL: I guess I am looking again for sort of some operating idea that would advance this No. 60 into some real face-to-face dialogue among the stakeholders, and whether it is regional gatherings that we are sponsoring, but something that tries to put in the minds of the reader the fact that we want to see the federal arm create the dialogue for more of this opportunity.

MR. DEVRIES: You want to facilitate it?

MR. CHAPPELL: Yes.

DR. GORDON: That sounds great.

MR. DEVRIES: Could the workgroup take a stab at that and come back with some language? That is a good recommendation. Thank you.

Any other comments, Issues 59 and 60? Effie.

SISTER KERR: Not Nos. 59 and 60. I just would like to say this. Back to the issue of the Senate bill and the dietary supplements, and I am saying this to us as a group.

David, you have got some really practical, good ideas. Sometimes I feel like there is collusion to fund the drugs, or dietary supplements that are so-called, maybe an idea being more creative. But, do you see where we still miss a different model, conceptually?

Like if we are going to fund a dietary supplement or drugs for anxiety, why aren't we just putting in there qigong, fund that and group therapy or something? Do you see?

I think, as a Commission, we need to start thinking that way, what would be a recommendation that is

a bit broader than supporting either drug companies or dietary supplements. It is a modality approach. It is not either/or, and that is fine. But we have got to do the either/or sometime in here.

MR. DEVRIES: Thank you.

DR. GORDON: I would just say, Charlotte, that is exactly the kind of recommendation and specificity, as well as embodying the philosophical approach, that can be included in Nos. 54, 55, 56, 57, some of those recommendations for looking at some of these approaches. I think it is important. That will give it a concreteness, as well as embody our whole philosophy.

MR. DEVRIES: Moving up to Issue No. 5, last issue, and Recommendations Nos. 61 through 63. I think the concept of providing information is that employers and health plans need more and better information on research, both clinical efficacy and safety, and comparative health services. They also need better information and understanding on the licensure of CAM providers and how that protects their patients and provides credible resources for them to work with, the availability of providers.

Basically, there are three recommendations, Nos. 61, 62, and 63, related to this. The first one being focused on the information through a federally-sponsored website, perhaps through CAM central that would provide employers and health plans with that type of information.

No. 62. Just to say quickly, that is really about where a CAM central or other various particular agencies to periodically report to Congress and the President the status of research, coverage, access, and availability of CAM services.

Finally, No. 63 is really to encourage the collaboration process that we have been talking about on development of information.

DR. GORDON: I have a couple thoughts on these. I like the recommendations. I think, on No. 62, that it should include Federal Employee Benefit Plan, and I think that they should be reporting not only to Congress, HHS, and the President, but also to all their members, letting them know what they are doing.

Do you follow what I am saying?

So, if you go to the VA, you ought to know, as